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BRIEF

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"Although soaring rates are not exclusive to the health insurance industry, the high cost of medical malpractice liability insurance is adding to the health care crisis in Texas and many other states."

The Medical Malpractice Liability Crisis

The medical malpractice liability insurance issue is not a new phenomenon but a new manifestation of a complex and as yet unresolved problem that states have periodically wrestled with for decades. Texas, like other jurisdictions, will address the same situation in the 78th Legislature.

History of Medical Malpractice Law in Texas

August 29, 1977: **Medical Liability and Insurance Improvement Act of Texas**, Article 4590i, Vernon's Texas Civil Statutes, becomes effective. The Act:

- Requires any health care liability claim to be filed within two years from the occurrence of the injury or from the date the medical or health care treatment is completed. Minors under the age of 12 years have until their 14th birthday to file the claim, or have the claim filed on their behalf. (Section 10.01)
- Caps recovery on a civil health care liability claim against a physician or health care provider at $500,000. This does not apply to damages awarded to cover the cost of past, present, or future necessary medical, hospital, and custodial care. (Section 11.02)
- Provides that if the cap in Section 11.02 is invalidated, the civil liability of a physician or health care provider for all past and future noneconomic losses recoverable by an injured person or the person's estate is capped at $150,000, including past and future physical pain and suffering, mental anguish and suffering, consortium, disfigurement, and any other nonpecuniary damage. (Section 11.03)
- Provides that the caps in Sections 11.02 and 11.03 shall be adjusted for increases or decreases in the consumer price index. (Section 11.04)

January 30, 1985: In *Neagle v. Nelson, et al*, 658 S.W. 2d 11 (Tex. 1985), the Texas Supreme Court rules that the two-year statute of limitations in Section 10.01 violates the "open courts" provision of the Texas Constitution (Article I, Section 13) to the extent that the statute bars a plaintiff from bringing a medical malpractice claim before the injured party had a reasonable opportunity to discover the injury.

May 11, 1988: In *Lucas v. U.S.,* 757 S.W. 2d 687, 691 (Tex. 1988), the Texas Supreme Court rules that the limitations on damages set out in Section 11.02 violate the "open courts" provision of the Texas Constitution.

The Medical Malpractice Liability Crisis

September 1, 1989: H.B. 18,71st Legislature, becomes effective. This bill adds Section 14.01 to Article 4590i to set out the qualifications for an expert witness in a health care liability claim.

September 1, 1993: Section 3 of S.B. 1409, 73rd Legislature, becomes effective, adding Sections 13.01 and 13.02 to Article 4590i. These sections require a plaintiff in a medical malpractice suit to file an affidavit that the plaintiff has obtained an expert opinion that the acts or omissions of a physician or health care provider were negligent and the proximate cause of harm to the plaintiff.

September 1, 1995: S.B. 25, 74th Legislature, becomes effective. The bill amends Section 41.008 of the Civil Practice and Remedies Code to limit exemplary damages that may be awarded against a defendant to the greater of:

- Two times the amount of economic damages, plus noneconomic damages found by the jury, not to exceed $750,000; or
- $200,000.

September 1, 1995: H.B. 971**,** 74th Legislature, becomes effective. The bill:

- Amends Section 13.01 to require that a plaintiff in a medical malpractice suit file a $5,000 bond or place that amount in escrow, for each defendant physician or health provider. In lieu of such bond or escrow, the plaintiff may file an expert report setting out the manner in which the care provided by a physician or health care provider failed to meet accepted standards and caused the harm claimed.
- Amends Section 14.01 to set out what a court must consider in determining whether an expert witness is qualified.
- Adds Subchapter P to Article 4590i, relating to the determination of prejudgment interest in medical malpractice suits.

August 24, 2000: In *Horizon/CMS Healthcare Corporation v. Auld*, the Texas Supreme Court makes the following rulings:

- The cap on damages in Section 11.02 does not include punitive damages, which serve the purposes of deterring and punishing wilful or wrongful conduct.
- The cap on compensatory damages in Section 11.02 is only unconstitutional as it applies to claims brought under common law, such as for personal injuries resulting from medical negligence. This cap does apply to causes of action that are not derived from common law but created by legislative enactment, such as wrongful death and survival claims.
- The statutory cap on punitive damages in Section 41.008 of the Texas Civil Practice and Remedies Code applies to punitive damages awarded in a health care liability claim.

June 27, 2002: In *Columbia Hospital Corporation of Houston v. Moore, et al***,** the Texas Supreme Court rules that any prejudgment interest awarded under Subchapter P of Article 4590i is subject to the cap on compensatory damages contained in Sections 11.02 and 11.03, Article 4590i.

July 24, 2002 – Lieutenant Governor Ratliff adds a second charge to theTexas Senate Special Committee on Prompt Payment of Health Care Providers asking the committee to "evaluate the effectiveness of existing state law and agency rules relating to the current medical professional liability system, assess the causes of rising malpractice insurance rates in Texas, including the impact of medical malpractice lawsuits and their impact on access to health care."

December 18, 2003 – Governor Perry declares that medical malpractice reform is to be an emergency issue for the 78th Legislature.

Perry laid out a series of corrective measures to be considered by the 78th Legislature in addressing medical malpractice reform.

Framing the Issue

Liability insurance rates are up across the board for all professions, including health care providers, attorneys, and building contractors. A decade of relentless price wars, aggressive investment risk-taking, and loosening of terms on all types of policies, including small and midsize business policies, workers' compensation, and medical malpractice packages, led to rates being slashed as much as 40 percent from 1992 to 2000. Insurers eventually reached their limit and were no longer able to offset losses with investment income. Now, in an already somber business climate, the higher cost of insurance is placing additional pressure on businesses.[1]

Medical malpractice insurance was the industry's most profitable line 10 years ago and generated intense competition, one element of which was the underpricing of coverage. The insurance price war of the 1990s, combined with rising jury verdicts in malpractice suits, helped to create malpractice insurance inflation. The nation's largest writer of medical malpractice insurance, St. Paul Company, is no longer offering medical malpractice insurance because it does not believe it can "make the line of business profitable" after losing $940 million in 2001.[2]

Although soaring rates are not exclusive to the health insurance industry, the high cost of medical malpractice liability insurance is adding to the health care crisis in Texas and many other states. Fewer insurers are offering medical malpractice coverage, forcing health care providers to limit their treatment and practices to generalized medicine or services and to avoid the more risky specialized treatments

involved in neurology, obstetrics, emergency medicine, and surgery. Citing unaffordable premiums, physicians are abandoning specialized medicine and even practices, and legislators are charged with finding effective solutions to ensure that health care practitioners have access to affordable medical malpractice insurance and that citizens have continued access to quality health care as well as access to the courts and fair compensation for injuries due to negligence.

The United States also experienced a medical malpractice crisis in the mid-1970s and mid-1980s. Every state enacted legislation to address the problem, and tort reform was a frequently used approach. Medical malpractice insurance remained predictable, stable, and highly profitable for most of the 1990s. The events of September 11, 2001, generated a significant number of large claims in a short period of time, and the subsequent economic instability has contributed to a rapid rise in premiums.

Premiums began to rise in 2000, and rate increases accelerated in 2002 approximately 20 to 25 percent nationally and up to 80 percent in some states. Premiums in Texas increased by .5 percent to 40 percent from 2001 to 2002. In high-risk specialties like neurology, emergency medicine, surgery, and obstetrics, premiums rose in some instances by 200 percent nationally, and physicians in Texas' Rio Grande Valley ranked sixth and seventh, respectively, in the nation for highest premium rates for general surgery and OB/Gyn practices.

The Cyclical Nature of the Crisis

Because malpractice cases have long "tails" (or extended periods of time between when premiums are collected and claims are paid), the importance of an insurer's investment income is increased. Generally, it takes three to six years for claims to "develop." When the stock market is highly profitable, insurers are able to offer premiums at bargain rates. Unfortunately, when the stock market conditions change for the worse, insurance solvency is threatened and insurers are forced to cover their losses with rate hikes. Higher premium rates are based on increased losses paid by insurers and declining investment incomes resulting from low interest rates and the volatile stock market. As losses mount and investment income declines for the insurance industry, some insurers lack the funds to cover claims. Eventually, premiums experience dramatic hikes and insurance becomes difficult to obtain.

The cyclical crisis especially affects health care providers practicing in high-risk specialty areas of medicine and patients in rural or lower socioeconomic areas. Managed care and the inability to pass costs on to patients prevent physicians from recouping the rise in premium costs.

Mistakes are Made

A November 1999 report by the Institute of Medicine (IOM) focused the nation's attention on the issue of medical errors and patient safety.[3] The report suggested that between 44,000 and 98,000 people die in hospitals each year as the result of medical errors, making medical errors the eighth leading cause of death in the U.S. The IOM report also noted that more than half of the adverse medical events occurring each year are preventable medical errors. The cost associated with these errors in lost income, disability, and health care is substantial. Because the consequences of medical errors are often serious and sometimes irreversible—leading to death or disability—the issue has received significant public attention.

Medical errors carry both a high financial cost and a social cost. The IOM report stated that the national costs per year of medical errors is approximately $37.6 billion, with about $17 billion of those costs attributable to preventable errors.

Errors occur in many health care settings, including hospitals, physicians' offices, nursing homes, pharmacies, urgent care centers, and home health settings; however, very little data exists on the extent of the problem outside hospitals.[4] This is largely due to the lack of consistency in laws requiring medical errors to be reported and tracked.

Many of these adverse events are associated with the use of pharmaceuticals and are potentially preventable. A recent report noted that medication errors were common, occurring in nearly one of every five doses in the typical hospital and skilled nursing facility.[5] The percentage of errors rated potentially harmful was seven percent, or more than 40 per day in a typical 300-patient facility. The report concluded that the problem of defective medication administration systems, although varied, is widespread.

Numerous studies have issued recommendations on measures that the various components of the U.S. health care system can take to reduce the incidence of medical errors.[6] Included among the proposals are reporting systems covering two primary types of medical error: mandatory

reporting focusing on medical errors that result in serious injury or death and voluntary reporting of errors leading to only minor injuries.

Although voluntary reporting systems have been generally well received, mandatory reporting systems have faced strong opposition.[7] Among the commonly cited reasons opposing mandatory reporting systems are the fear of being blamed, the potential for legal liability, and an expectation that such reports will have no effect. A recent collaborative report by the Institute for Healthcare Improvement and the National Coalition on Health Care noted that the "fear of malpractice litigation thus becomes a major barrier to openly discussing or reporting errors."[8]

Although reporting systems that document adverse events collect valuable data, they are not sufficient, in themselves, to improve medical care. Accurate information is needed on the process, the care provided, and the patient's response to that care. This data can then be analyzed to identify specific changes in health care systems and processes that can reduce the likelihood of adverse events caused by both medical errors and the normal risks of adverse outcomes inherent in all medical interventions.

Possible Solutions

There are four categories of action that states generally consider in responding to the complex problems arising from medical errors and the rising cost of medical malpractice insurance.

- Prevention
- Liability / Tort Reform
- Judicial Reform / Alternatives to Litigation
- Insurance Options

Prevention

Preventing or eliminating conditions that lead to malpractice is a proactive approach to dealing with the problem of rising insurance costs. Advocates for prevention acknowledge that this requires aggressive action at the state level and by health care providers.

Prevention measures include:

- Increased enforcement and disciplinary actions by state medical boards,
- Risk-management programs,
- Instituting programs of best practices,
- Tougher licensing requirements,
- Stronger and enforced professional standards, and
- Restrictions on health professionals' work hours.

State Boards of Medical Examiners / Enforcement

State boards of medical examiners need appropriate funding to effectively investigate complaints, enforce the laws granting their authority, and assure that the members of the medical profession are adequately trained, supervised, and disciplined when appropriate. Reports from the General Accounting Office (GAO) have shown that relatively few physicians and other practitioners are disciplined appropriately by professional or state agencies. In 1984, GAO reported that a health care practitioner licensed in more than one state could have one of those licenses revoked or suspended by a state licensing board but could relocate to another state and continue to treat patients. The 100th Congress passed HR1444 in 1987 establishing a period of exclusion from participation in Medicare and some state health care programs for health care practitioners whose licenses have been suspended.

Advocates for preventive measures to address medical malpractice lawsuits claim that a properly functioning medical review board can serve as an alternative to litigation and assure that injured patients are adequately and quickly compensated by effectively disciplining problem doctors. California and other states have increased and adjusted funding for medical review boards and have allocated a greater percentage of those funds for enforcement.

Risk Management

The 1987 GAO report *Medical Malpractice: A Framework for Action* states that "state legislatures, where they have not yet done so, should require health care providers to participate in risk-management programs as a condition of licensure."

Some preventive programs include early warning systems for adverse patient outcomes, which enable the provider organization to promptly investigate the situation and take appropriate actions to prevent a recurrence, thus averting a potentially litigious situation.

Improved communication between the doctor and patient, with informed consent and counseling, can better educate patients about the risks of medical treatments, or likely and possible outcomes of medical procedures.

Liability / Tort Reform

With the insurance industry, physicians, and other health care providers citing medical malpractice lawsuits as the cause of sky-rocketing insurance premiums, tort reform remains the most popular solution in addressing high insurance premiums.

The Medical Malpractice Liability Crisis

Tort reform is seen as a way to control the frequency and severity of claims and to stabilize insurance premiums.

Proponents of tort reform point to an increase in big jury awards, large settlements in medical malpractice lawsuits, and a growing number of lawsuits as the causes of medical malpractice liability premiums rising to unaffordable amounts.

Caps on Noneconomic Damages

At the heart of most tort reform is a cap on noneconomic damages, i.e., damages not tied to specific costs. These damages are much more difficult to calculate than economic damages (e.g., lost wages and medical costs). Proponents argue that these awards are often high due to the emotional reactions of overly sympathetic juries rather than a reflection of actual harm.

Among those who strongly advocate caps are the Texas Association of Business (TAB), the Texas Association for Patient Access, the Texas Association of Homes and Services for the Aging, and the Advocates for Long Term Care Nurses. TAB has recommended a $200,000 cap; the others suggest capping noneconomic damages at $250,000.

Those who oppose caps assert that the solution is not as simple as tort reform advocates contend. Carlton Carl, director of media relations for the Association of American Trial Lawyers, states that "a limit on medical malpractice insurance [damages] penalizes patients most severely injured by medical malpractice."[9]

In 1999, the Center for Justice & Democracy (CJ&D) released *Premium Deceit – the Failure of "Tort Reform" to Cut Insurance Prices.* The analysis stated that "despite years of claims by insurance companies that rates would go down following enactment of tort reform, [we] found that tort law limits enacted since the mid-1980s have not lowered insurance rates in the ensuing years."[10] In response, Debra Ballen, American Insurance Association executive vice president, stated in a press release that "insurers never promised that tort reform would achieve specific premium savings."[11]

CJ&D argues that "states with little or no tort law restrictions have experienced approximately the same changes in insurance rates as those states that have enacted severe restrictions on victims' rights." The center claims that insurance is a cyclical business and that, as was the case with the last insurance crisis, "eventually rates will stabilize and availability will improve around the country, irrespective of tort law restrictions enacted in particular states."

Caps on Economic Damages

Five states set limits for total damage awards, limiting both noneconomic and economic damages. Total damage caps frequently work in conjunction with state-run patient compensation or excess funds. The National Center for State Courts reported in 1992 that caps on economic damages had no impact on the rate of malpractice litigation.[12]

Restrictions on Attorney Contingency Fees

Attorneys for plaintiffs in tort cases almost always work on a contingency fee basis, receiving a percentage of any damage award. Contingency systems make it possible for people of all economic levels to bring suit for injuries resulting from negligence. Proponents of tort reform argue that attorney fees are often excessive, affect the victim's level of compensation, and encourage attorneys to bring frivolous suits.

Additionally, proponents argue that the personal tragedy of a patient who has suffered harm should not result in a windfall for plaintiff attorneys and believe that Texas should adopt a fee structure where attorney fees are capped at 33 percent of the initial $100,000 in damages and decrease as the amount of the recovery increases.

Statute of Limitations

The Texas Supreme Court ruled that an absolute two-year statute of limitations in Texas medical malpractice claims violated the Texas Constitution to the extent that the statute barred a plaintiff from bringing a medical malpractice claim before the injured party had a reasonable opportunity to discover the injury.[13] Texas still has a two-year statute of limitations for medical malpractice claims, but if a person could not have reasonably discovered the injury during that period, the statute of limitations becomes a question of fact to be determined on a case-by-case basis by the court.

Tort reform proponents support statutes of limitations, similar to those enacted in California, Nevada, and Mississippi, arguing that shorter statutes of limitations for filing claims can reduce the frequency of claims.

Periodic Payments

A plaintiff who suffers bodily injury has traditionally been compensated for both past and future damages through a lump-sum judgment payable at the conclusion of the trial. Those urging tort reform believe that the adoption of a periodic payment procedure would benefit both plaintiffs and defendants. It is argued that lump-sum awards can be dissipated by unwise expenditures or investments before the injured person actually incurs the future medical expenses or earning losses. Periodic payments may spare defendants the financing problems created by single large award payments. Periodic payments may also prevent bankruptcy for providers who lose malpractice suits.

Supporters of periodic payment systems recommend that, at the option of either the defendant or the claimant, all future damages in excess of $100,000 be paid by periodic payments rather than in a lump sum. The judgment would specify how and when the periodic payments are to be made. Periodic payments of future medical, hospital, and custodial care would be paid as incurred and terminate on the death of the recipient.

Nearly two-thirds of the states have adopted policies that provide for courts to order periodic payments. Four jurisdictions have considered the constitutionality of periodic payment provisions. Two have found them constitutional, and two have found them unconstitutional.

Collateral Source Rule

The collateral source rule prohibits juries from hearing evidence that claimants have been fully or partially compensated from other sources (e.g., medical insurance) for their injuries.

Those who support reforming the collateral source rule make the following recommendations relating to the rule:

- Allow the introduction of alternate sources of recovery for the claimant. The claimant may introduce evidence of the amount paid to secure the right to insurance benefits.
- Prohibit the payer of collateral benefits from recovering the amounts paid to the claimant and from having the right of subrogation, except as authorized by federal law.
- Limit the recovery of medical or health care expenses associated with a liability claim to the actual amount paid or incurred on behalf of the claimant.

Those urging tort reform do not necessarily favor a total abolition of the collateral source rule, especially if such an abolition would alter workers' compensation laws.[14]

One alternative to Texas' current rule is to reallocate an insolvent defendant's share of liability among all parties according to their proportionate fault, including the negligent plaintiff.

Penalties for Frivolous Lawsuits

Chapter 10 of the Texas Civil Practice and Remedies Code requires an attorney who brings a lawsuit by way of signature to swear that the suit is not frivolous or without merit. It is then left to the judge's discretion to determine whether a pleading has been signed in violation of any one of the standards prescribed by law. Opponents of tort reform argue that current Texas law contains adequate prohibitions against the filing of frivolous lawsuits and should not be changed.

Proponents of medical malpractice tort reform support even stronger penalties and sanctions for filing frivolous lawsuits. In July 2002, District Judge Ronald M. Yeager granted the motion for sanctions against an attorney of $25,000 per doctor after the attorney signed what the judge determined to be frivolous medical malpractice lawsuits against two doctors for prescribing medications that they had not prescribed.

The California Model Medical Injury Compensation Reform Act

The Medical Injury Compensation Reform Act (MICRA), passed in California in 1975, has been held up by many to be a model of reform addressing the problems of medical malpractice liability and is the favored model of physicians and liability insurers.

Dr. Richard G. Roberts, JD, board chairman of the American Academy of Family Physicians, states that "MICRA has helped California avoid some of the cyclical ups and downs in insurance costs that occur when insurers face a decline in their investment returns."[15]

MICRA includes four major provisions:

- Noneconomic damages against each defendant in a medical liability suit are capped at $250,000.
- Physicians and their lawyers are allowed to mention to juries that the patient has recovered part of the total damages from an insurer, family member, or other source.
- Defendants found liable for future damages are allowed to pay periodically rather than in a lump sum.
- Contingency fees paid to patients' lawyers are limited. Under MICRA, plaintiffs' lawyers are entitled to a maximum of 40 percent of the first $50,000 awarded, 33 percent of the next $50,000, 25 percent of the next $500,000, and 15 percent of any amount over $600,000.

According to the Health Care Liability Alliance (HCLA), a national advocacy coalition of doctors, hospitals, and health care insurers, under MICRA, the injured person receives the money awarded by the court for damages, and out-of-court settlements are encouraged.

At the same time California enacted MICRA, the state increased the budget for the Medical Board of California, the entity that licenses medical doctors, investigates complaints, and disciplines those who violate the law. California currently budgets approximately $32 million annually for its medical board to regulate close to 87,000 physicians, with 70 percent earmarked for enforcement. By comparison, Texas budgets $5.25 million annually for the Texas State Board of Medical Examiners to regulate approximately 37,000 physicians, with a little over 42 percent designated for enforcement. California has continued to adjust the agency's budget to address backlogs of cases to be investigated.

The Medical Malpractice Liability Crisis

Judicial Reform / Alternatives to Litigation

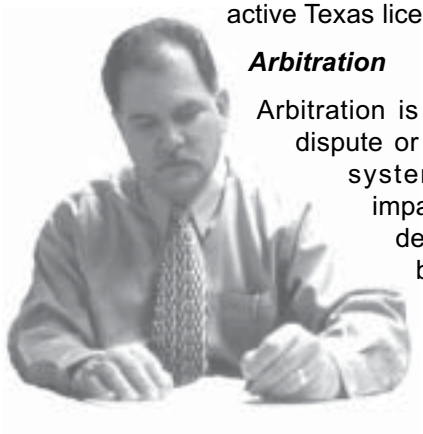
Expert Witness Requirements

According to Steven Goode, JD, a professor at The University of Texas School of Law, "expert testimony provides evidence that the doctor departed from the standard of care, and establishes causation by testifying what the doctor did to cause an alleged injury."[16]

Advocates for judicial reform propose strengthening expert witness requirements and allowing the defense to immediately appeal a decision on expert witness qualifications or a trial judge's failure to dismiss a lawsuit when expert witness reporting requirements are not met.

The Texas Alliance for Patient Access (TAPA) and the Texas Medical Association (TMA) support a reform package that links the qualifications of experts more closely to the alleged malpractice and limits a trial judge's discretion in determining who qualifies as an expert.

Reforms proposed by TAPA and TMA increase the qualifications of expert witnesses and require them to have practiced in the particular area of medicine about which they will be testifying.[17] Some reformers would also require that the expert witness affidavit be completed by an active Texas licensee.



Arbitration

Arbitration is the process of resolving a dispute or grievance outside the court system by presenting it to an impartial third party or panel for a decision that may or may not be binding. Arbitration is permitted in some states (including Texas)[18] and is often a prerequisite to litigation. Arbitration may address liability and the amount of damages.

Screening Panels

Mandatory, pretrial screening panels are intended as a means to increase the effectiveness and efficiency of processing tort claims, to reduce the number of frivolous claims, and to speed up settlement and payment to injured parties with legitimate claims. Some states (not including Texas) use review or screening panels as a pretrial screening mechanism, but findings may or may not be submitted as evidence, depending on the state.[19] If the panel's decision is allowed into evidence, the panel members can be called as witnesses at trial.

Some state courts have found that screening panels, as a prerequisite to a jury trial, constitute an impermissible restriction on the right to trial by jury or the open courts provision guaranteed in their state constitutions. Some screening panels, initially found constitutional by the state courts, have subsequently been invalidated because they have proven impractical. Long delays caused by the procedures have effectively denied plaintiffs access to the courts, and consequently the statutes have been found unconstitutional as applied.[20]

Insurance Options

Insurance reforms designed to increase the availability of malpractice insurance include:

- **Patient compensation funds.** Nine states (not including Texas) currently have patient compensation funds that pay portions of especially costly awards that are in excess of the coverage limits of a malpractice insurance policy.
- **Joint underwriting associations (JUAs).** The Texas Medical Liability Trust covers about one-third of the state's doctors, and the number of policyholders at the JUA has more than tripled in less than a year. JUAs operate in 11 states including Texas.
- **Limits on the ability of companies to cancel policies**.
- **Requirements that insurers report the disposition of claims to insurance regulators.**

Medical Malpractice in the 50 States

The insert of this publication is a table outlining several key elements of the medical malpractice system in the 50 states.

Conclusion

State legislatures typically respond to a medical malpractice crisis with packages that include multiple reforms that share the common goals of marketplace stability and fair compensation for victims.[21] Most legislators agree that the medical malpractice problems their states are facing will not be resolved until every aspect of the equation — from actual physician malpractice to rapidly increasing insurance rates and high jury awards — is considered.

—by Samm Osborn, SRC

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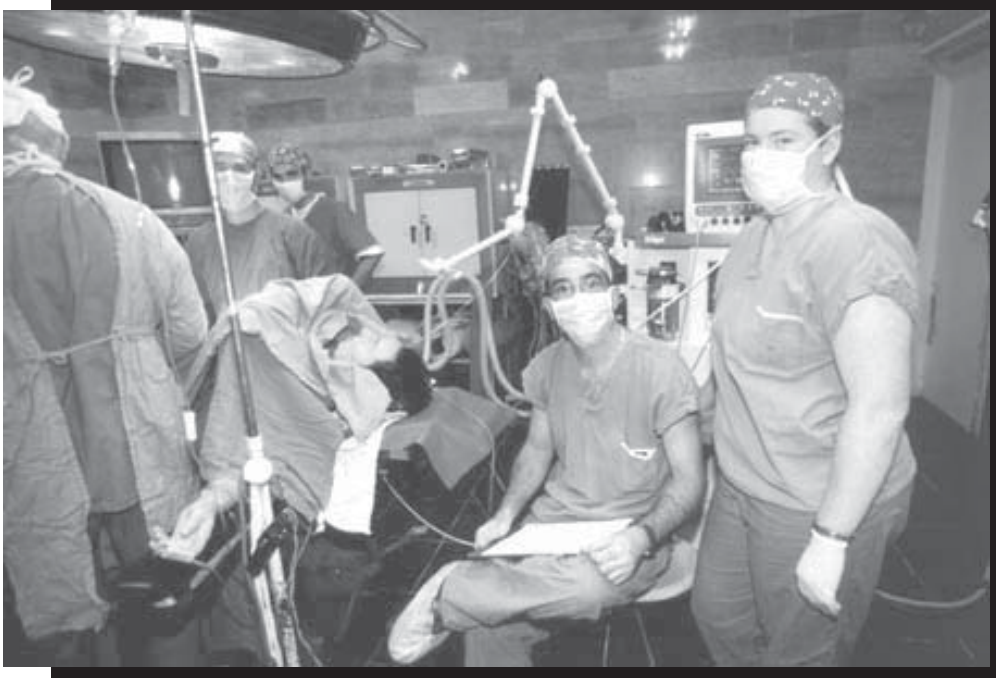
STATE	Statute of Limitations	Caps on Awards	Collateral Source Rules	Periodic Payments	Pretrial Screening	Expert Witness Rules	Attorneys' Fees
Alabama	2 yrs from injury or 6 mo from discovery	noneconomic damages	discretionary offset	mandatory		same specialty	
Alaska	2 yrs from discovery	noneconomic damages	mandatory offset	discretionary	mandatory	same specialty & state	
Arizona	2 yrs from injury	none	discretionary offset	discretionary			court's discretion
Arkansas	2 yrs from Injury	none		discretionary			
California	3 yrs from injury or 1yrs from discovery	on noneconomic damages	discretionary offset	mandatory			sliding scale
Colorado	2 yrs from accrual	various	mandatory offset	mandatory	mandatory		
Connecticut	2 yrs from discovery 3 yrs from act	none	mandatory offset	discretionary	voluntary		sliding scale
Delaware	2 yrs from injury 3 yrs from discovery	none	discretionary offset	discretionary	mandatory		sliding scale
Florida	2 yrs from injury or discovery	on economic & noneconomic	mandatory offset	mandatory	discretionary	same specialty or 5 yrs exp.	sliding scale
Georgia	2 yrs from injury	on punitive	admissible		voluntary		
Hawaii	2 yrs from discovery	on noneconomic damages			mandatory		approved by court
Idaho	2 yrs from injury	on noneconomic damages	mandatory offset	discretionary	mandatory		
Illinois	2 yrs from discovery	on noneconomic damages	may apply for reduction of	voluntary or discretionary			sliding scale
Indiana	2 yrs from act	various	admissible	discretionary	mandatory		limited
Iowa	2 yrs from discovery	none	mandatory offset	discretionary			court's discretion
Kansas	2 yrs from act or discovery	on noneconomic damages	admissible		voluntary		
Kentucky	1 yr from act or discovery	none	discretionary offset				
Louisiana	1 yr from act or discovery	various					
Maine	3 yrs from injury	on noneconomic damages	mandatory offset	mandatory	mandatory		sliding scale
Maryland	5 yrs from act or 3 yrs from discovery	on noneconomic damages		discretionary	discretionary		court's discretion
Massachusetts	3 yrs from injury	on noneconomic damages	mandatory offset		mandatory		sliding scale
Michigan	2 yrs from injury	on noneconomic damages	mandatory offset	conditionally mandatory	mandatory	similar specialty	limited
Minnesota	2 yrs from Injury	none	mandatory offset	discretionary			
Mississippi	2 yrs from act or discovery	none					
Missouri	2 yrs from act or discovery	on noneconomic damages		mandatory			
Montana	3 yrs from injury or discovery	on noneconomic damages	mandatory offset	mandatory	mandatory		
Nebraska	2 yrs from act or 1 year from discovery	various	credited		mandatory		subject to court review
Nevada	3 yrs from injury or 2 yrs from discovery	various	mandatory offset	discretionary		similar specialty	subject to court review
New Hampshire	3 yrs from injury or discovery	on noneconomic damages	abolished	discretionary			subject to court review
New Jersey	2 yrs from accrual or discovery	on punitive	mandatory offset		voluntary		sliding scale
New Mexico	3 yrs from injury	all		mandatory	mandatory		
New York	2 1/2 yrs from injury	none	mandatory offset	mandatory	voluntary		sliding scale
North Carolina	3 yrs from act or 1 yr from discovery	on punitive			mandatory		
North Dakota	2 yrs from act or discovery	on noneconomic & discretionary on economic	discretionary offset	discretionary	mandatory		

STATE	Statute of Limitations	Caps on Awards	Collateral Source Rules	Periodic Payments	Pretrial Screening	Expert Witness Rules	Attorneys' Fees
Ohio	1 yr from discovery	various	admissible	mandatory	voluntary		
Oklahoma	2 yrs from discovery	on punitive	discretionary offset				limited
Oregon	2 yrs from discovery	none	discretionary offset				limited
Pennsylvania	2 yrs from injury or or discovery	on punitive			mandatory		
Rhode Island	3 yrs from injury or discovery	no punitive damages	mandatory offset	discretionary			
South Carolina	3 yrs from injury or discovery	none					
South Dakota	2 yrs from injury	on noneconomic damages	discretionary offset	mandatory	voluntary		
Tennessee	1 yr from discovery	none	mandatory offset		voluntary	must be licensed in Tennessee or contiguous state	limited
Texas	2 yrs from discovery	various				must have related experience	
Utah	2 yrs from discovery	on noneconomic damages	mandatory offset	mandatory	mandatory		limited
Vermont	3 yrs from injury or 2 yrs from discovery	none			mandatory		
Virginia	2 yrs from injury	various		permitted	voluntary	must have related experience	
Washington	3 yrs from injury or 1 yr from discovery	on noneconomic damages	discretionary offset	mandatory			court's discretion
West Virginia	2 yrs from injury or or discovery	on noneconomic damages				similar specialty	
Wisconsin	3 yrs from injury or 1 yr from discovery	on noneconomic damages	admissible	permitted	voluntary		sliding scale
Wyoming	2 yrs from injury or or discovery	none					sliding scale

Source: National Council of State Legislatures



"Liability insurance rates are up across the board for all professions, including health care providers, attorneys, and building contractors."